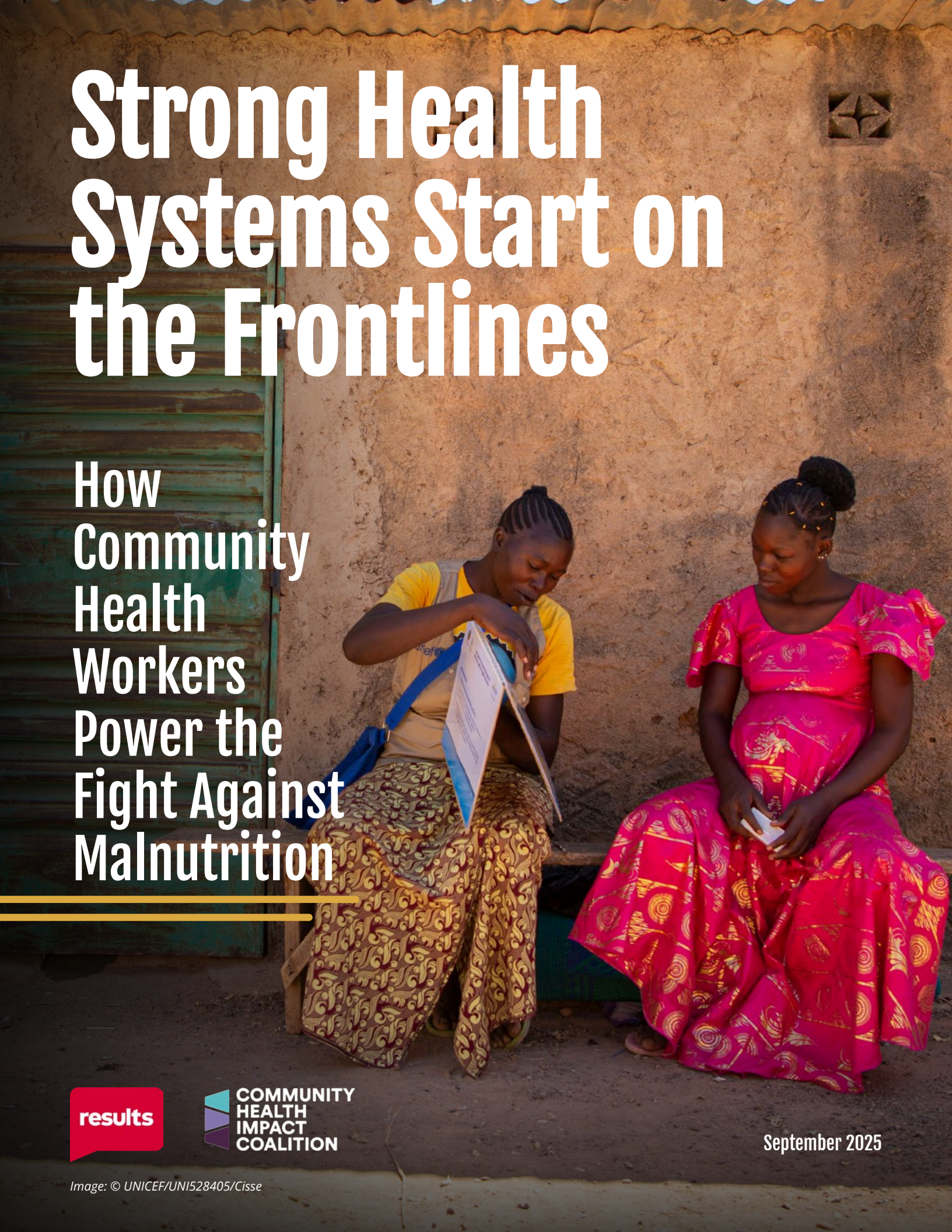
Strong Health Systems Start on the Frontlines

How Community Health Workers Power the Fight Against Malnutrition



results

COMMUNITY HEALTH IMPACT COALITION

September 2025

Image: © UNICEF/UNI528405/Cisse

Community Health Worker Budhani Devi Khang visits the pregnant women in her locality and counsels them regarding the importance of a nutritious diet, folic acid, and regular follow up during pregnancy in Pipraparba, Saptari.

Image: © UNICEF/UN0638960/Upadhayay

Acknowledgements

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Note from the author //

This report is dedicated to my great-uncle, Dr. Abel Gousse, whose stories of long journeys by mule and remarkable ingenuity to deliver health care to the most remote communities in rural Haiti have been passed down to me and continue to inspire.

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Table of Contents

Glossary of Terms

A

ANEMIA

Anemia is a condition where the number of red blood cells or the amount of haemoglobin is lower than normal, reducing the blood's ability to carry oxygen. This can cause fatigue, weakness, dizziness, and shortness of breath. It can result from poor nutrition, infections, chronic diseases, blood loss, or inherited disorders. It particularly affects women and girls of reproductive age[1].

C

COMMUNITY HEALTH WORKERS (CHWs)

Essential frontline health care providers who come from the communities they support. They play a vital role in connecting underserved groups with the formal healthcare system. Their shared language, cultural values, and social context allow them to effectively reach individuals who might otherwise be excluded from care[2].

G

GLOBAL HEALTH INITIATIVES (GHIs)

Organizations that coordinate international efforts to mobilize and allocate funding to address major health challenges, particularly in low- and middle-income countries. They support the implementation of health programs, often in partnership with national governments and local stakeholders. GHIs play an important role in shaping global health, and these institutions invest billions annually in solutions and systems in low- and middle-income countries[3].

I

INTERNATIONAL DEVELOPMENT ASSOCIATION (IDA)

The World Bank's arm that works in low- and lower-middle income countries. It is funded largely by contributions from the governments of high-income countries and lends money (known as credits) on concessional terms. This means that IDA credits have no or very low interest charge, and repayments are stretched out over 35 to 40 years, including a 10-year grace period. IDA also provides grants to countries at risk of debt distress[4].

IMPLEMENTING COUNTRIES

Countries—primarily low- and middle-income—that actively participate in global health initiatives by implementing programs, receiving support for health interventions, or contributing to research and policy development. These countries engage in collaborative efforts to improve health outcomes, often through initiatives focused on prevention, treatment, and strengthening health systems.

N

NUTRITION-SENSITIVE

Nutrition-sensitive interventions are programs implemented in sectors outside of nutrition that address the underlying determinants of malnutrition, thereby contributing indirectly to improved nutritional outcomes. These sectors—such as agriculture, health, social protection, early childhood development, education, and water and sanitation—target root causes like poverty, food insecurity, inadequate caregiving resources, and limited access to essential services[5].

NUTRITION-SPECIFIC

Nutrition-specific interventions are those which have a direct impact on the immediate causes of undernutrition (inadequate food intake, poor feeding practices and high burden of disease) such as breastfeeding, complimentary feeding, micronutrient supplementation and home fortification, disease management, treatment of acute malnutrition, and nutrition in emergencies[6].

O

OFFICIAL DEVELOPMENT ASSISTANCE (ODA)

Official development assistance is government aid that promotes and specifically targets the economic development and welfare of low- and middle-income countries. ODA has been the main source of financing for development aid since 1969 and is monitored and tracked by the Organisation for Economic Co-operation and Development (OECD)[7].

PRIMARY HEALTH CARE (PHC)

Primary health care is a people-centred approach that brings essential health services closer to communities. It supports lifelong health—from health promotion to disease prevention, treatment, rehabilitation, palliative care, and more. It addresses factors like housing and education and empowers people to care for their own health. It's the most fair and effective way to achieve health for all and to prepare for future health challenges[8].

STUNTING

Stunting is defined as low height-for-age. It is the result of chronic or recurrent undernutrition, usually associated with poverty, poor maternal health and nutrition, frequent illness, and/or inappropriate feeding and care in early life. Stunting prevents children from reaching their physical and cognitive potential[9].

UNDERNUTRITION

Undernutrition is a type of malnutrition characterized by a person's insufficient intake of energy and/or nutrients. Wasting, stunting, underweight, and micronutrient deficiencies are different types of undernutrition.

UNIVERSAL HEALTH COVERAGE (UHC)

Universal health coverage means everyone can access quality health services when and where they need them without financial hardship. It includes a full range of services, from prevention to palliative care. Achieving UHC requires strong, equitable health systems rooted in communities, with PHC as the most efficient foundation[10].

WASTING

Wasting is defined as low weight-for-height. It often indicates recent and severe weight loss, although it can also persist for a long time. It usually occurs when a person has not had food of adequate quality and quantity and/or they have had frequent or prolonged illnesses. Wasting in children is associated with a higher risk of death if not treated properly[11].

MUAC measurement confirms child is severely malnourished. The Kasese region in Uganda is a hotspot for stunted growth among children with a rate of 40%, surpassing the national prevalence rate of 25%.

Image: © UNICEF/UNI483047/Rutherford

Executive Summary

Malnutrition remains one of the most urgent and solvable threats to child survival and healthy development in low- and middle-income countries. Community health workers (CHWs) are essential to addressing this crisis. Positioned at the heart of communities, they deliver vital nutrition and primary health services to families who are often missed by formal health systems.

Yet, despite decades of evidence showing their effectiveness, CHWs remain undervalued, under-supported, and frequently left out of national health systems—held back by chronic funding gaps and a lack of political commitment.

A deepening nutrition financing crisis, driven by longstanding underinvestment and recent shifts in donor priorities, is placing frontline care at serious risk. Nutrition programs have historically received less than 1% of official development assistance (ODA), and recent cuts, including the dismantling of key U.S. Agency for International Development (USAID) contracts, are worsening the situation. In Africa alone, up to 50% of CHW programs are now at risk. These community-based efforts, which are essential to delivering integrated nutrition and primary health care, face mounting threats as global needs continue to rise.

CHWs bridge the gap between fragile health systems and underserved families. By delivering services, such as growth monitoring, nutrition counselling, maternal and child health care, immunization, and timely referrals, they provide cost-effective, continuous, and culturally relevant care. When nutrition services are integrated into routine CHW services—rather than delivered as stand-alone campaigns—families receive the support they need to both prevent and treat malnutrition.

Governments, donors, and global institutions all have a role to play. Ultimately, whether through bilateral aid, multilateral financing, or country budgets, our collective success against malnutrition hinges on bold, coordinated support for the frontline health workers who make universal health coverage a reality—one household and one child at a time.

Beyond nutrition, CHWs help expand health systems reach, improve equity, and generate vital data. Their presence in communities also positions them to detect and respond to emerging disease outbreaks, making them an essential asset in pandemic preparedness and response efforts. Furthermore, achieving universal health coverage—the principle that everyone should have access to the care they need, when and where they need it, without financial hardship—will require robust investment in primary health care, with CHWs at the centre.

This report draws on existing research as well as consultations and interviews with CHWs in Africa, the Caribbean, and South America, alongside perspectives from advocates and case studies provided by global health initiatives. By combining data with frontline perspectives, this report underscores the need to professionalize CHWs by ensuring fair pay, quality training, and protection for their rights and well-being.

Recommendations

Recommendations to:

Implementing Governments

For World Children's Day, children take over the National Assembly, in Abidjan, southern Côte d'Ivoire.

Image: © UNICEF/UNI677394

1 Ensure Fair Pay and Legal Recognition

- Integrate CHWs into national health workforce, ensuring regular and sufficient pay, with access to promotions, hazard pay, and incentives aligned with other healthcare workers.
- Formally recognize CHWs in national law and health policies as essential health workers.

2 Provide Training and Supervision

- Provide regular, standardized training for CHWs that goes beyond emergency or campaign-based interventions.
- Define clear roles within the primary health care systems.
- Ensure career progression and representation in decision-making.

3 Maintain Consistent and Adequate Access to Infrastructure and Supplies

- Build and maintain adequate infrastructure, including safe spaces for care delivery, transportation, rainy-season equipment, and supervision.
- Provide CHWs with consistent and replenished supplies, from medications to malnutrition monitoring tools (mid-upper arm circumference (MUAC) tapes, scales, etc.).

Recommendations

Recommendations to:

Donor Governments

1 Channel Long-Term and Flexible Funding for CHWs and Strengthen Primary Health Care Through Multilateral and Bilateral Investments

- Provide robust, long-term and flexible funding to global health initiatives—such as the Child Nutrition Fund, Gavi, the Global Financing Facility, and the Global Fund—with earmarked support for integrated, CHW-delivered services across child and maternal health, including nutrition, immunization, and disease prevention.
- Leverage donor leadership roles within these global health initiatives governance bodies and replenishment platforms to ensure CHWs are prioritized in strategy, financing, and program implementation.
- Foster synergies among donors and partners, local ownership and sustainability through coordinated financing mechanisms at the country level to reduce fragmentation, increase the impact of primary health care investments, and ensure donor support is aligned with national systems and national health and social protection strategies.
- Complement multilateral contributions with bilateral investments with implementing countries and non-governmental organizations (NGOs) that strengthen community health programs, enabling CHWs to deliver across sectors and reach underserved populations.

2 Promote Integrated, Community-Based Health Systems

- Invest in integrated service delivery models that combine nutrition, immunization, maternal and newborn care, infectious disease, and social protection—through community-rooted, primary health systems.
- Expand CHW capacity through training, digital tools, and reliable supervision.
- Support national monitoring and evaluation systems to capture CHW contributions and drive performance across sectors and improve nutrition outcomes.

3 Promote CHW Leadership and Inclusion in Global Health

- Fund CHW-led organizations and advocacy efforts to strengthen domestic recognition, financing priorities, and policy change.
- Ensure CHWs and other frontline actors are meaningfully represented in global health decision-making platforms (e.g. Gavi Board, GFF Investors Group, etc.) and actively participate in donor-funded research and program management.

Recommendations

Recommendations to:
The World Bank

1 Scale Up Nutrition Investments in Primary Health Care

- Increase approval of nutrition-sensitive projects that prioritize community-led interventions and integration within primary health care systems.
- Expand the proportion of food and nutrition security projects that address the health-related dimensions of malnutrition, with a focus on prevention, early detection, and treatment at the community level.
- Ensure that nutrition services delivered by CHWs are embedded within broader efforts to expand universal health coverage (UHC), especially in underserved and fragile settings.

2 Set Measurable Goals and Drive Accountability

- Define clear, time-bound targets for the population reached by nutrition and CHW-delivered services, aligned with the Bank's overarching goal of reaching 1.5 billion people with health services.
- Publish disaggregated metrics by intervention type (e.g., stunting, wasting, anemia) to improve transparency and inform decision-making.

Top Image: The World Bank Group, WBG, Washington DC.
© Photograph by: Aja Suresh, June 21, 2024.

Background Image: Access to primary health care in the Amazonian communities of Datem del Marañón, Peru, remains a significant challenge.
© UNICEF/UNI510952/Pajuelo

Recommendations

Recommendations to:
Global Health Initiatives

1 Align and Finance Country-Led Community Health Strategies

- Support country-led, integrated, and inclusive community health strategies by coordinating financing, reducing out-of-pocket costs with a view of eliminating them for the poorest, and aligning budgets.

2 Professionalize and Institutionalize CHWs

- Promote fair pay, standardized training, regular supervision, risk protection, and career progression for CHWs—guided by World Health Organization (WHO) standards.

3 Strengthen Resilience and Outreach Capacity

- Support CHWs to navigate climatic challenges, remote settings, and crisis-affected communities safely by collaborating with implementing countries to improve outreach through infrastructure or mobility partnerships.

4 Drive Political Commitment and Accountability

- Build political will through high-level advocacy, engagement with influencers, and evidence-based investment cases.
- Establish global accountability frameworks with common indicators, gender-disaggregated data, and measurable milestones to track progress and improve impact.

In Alta Verapaz, Guatemala, a group of smiling children between the ages of 8 and 13, with glasses of safe water. The lack of access to safe water has a negative impact on the health, nutrition, education, and other aspects of the lives of children and adolescents.

Image: © UNICEF/UN0832031/Quintero

Malnutrition Crisis

Urgent Call to Action for Global Health

The Current State of Malnutrition

The global nutrition crisis is one of the most pressing challenges of our time, directly impacting millions of lives and undermining development, particularly in low- and middle-income countries.

A Complex, Costly Crisis

Malnutrition is not just about hunger. It encompasses undernutrition, micronutrient deficiencies, and diet-related chronic diseases, all of which are rising. The consequences are staggering: **malnutrition costs the global economy US$761 billion every year[12]. Undernutrition alone contributes to an estimated US$3.5 trillion in productivity losses each year**, especially in low-income countries, and limits educational achievement, increases health care costs and reduces workforce capacity[13].

A Gender and Intergenerational Issue

Malnutrition disproportionately affects women and girls—with over one billion suffering from undernutrition and severe deficiencies in essential micronutrients around the world. These deficiencies don't just affect individuals; they have devastating intergenerational consequences. Anemic mothers are more likely to give birth to infants at high risk of becoming wasted, as well as suffering from growth and developmental delays. This is why regions with high levels of maternal undernutrition also see high rates of child undernutrition[14].

A Crisis Accelerated by Conflict and Climate

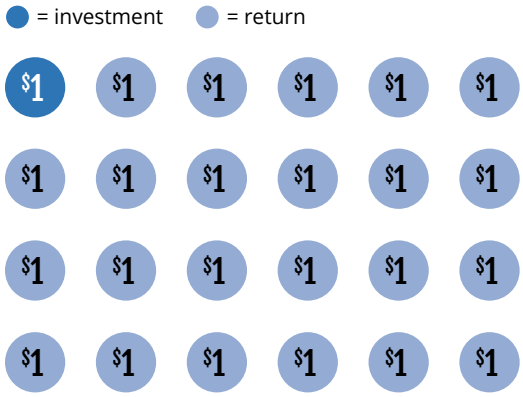
In the 15 countries hardest hit by multiple crises, a child is pushed into severe malnutrition every minute[15]. Globally, nearly half of all deaths among children under five are linked to undernutrition. In many of these contexts, conflict is a key driver of hunger or, at the very least, an aggravating factor, often hitting the most marginalized communities.

A Fragile Funding Landscape

Despite its wide-reaching impacts, nutrition remains drastically underfunded. Less than 1% of official development assistance (ODA) is allocated to nutrition-specific interventions. Total ODA from members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD) declined by 7.1% in 2024 compared to 2023 and is projected to decline by around 28% by 2026 compared to 2023.

The cancellation of major U.S. Agency for International Development (USAID) contracts alone is expected to result in funding cuts of at least 39% for the nutrition sector[16]. These cuts also jeopardize integrated, community-based primary health systems, which are essential for achieving sustained improvements in nutrition. In Africa alone, the termination of USAID support puts up to 50% of CHW programs at risk, threatening both immediate and long-term health and nutrition outcomes[17]. These cuts would threaten essential nutrition services to at least 14 million children[18].

Investing in nutrition is one of the smartest, most cost-effective ways to drive human, social, and economic development[19].



Every US$1 invested in reducing undernutrition yields a *US$23* return to a country's economy and society.

Scaling up proven nutrition interventions could generate *US$2.4 trillion* in economic benefits.

Investing in Nutrition Through Primary Health Care and Community Health Workers: A Smart, Strategic Response

Over half of the world's population lacks access to essential health services[20]. For many, this is because they live in communities—whether remote rural areas or crowded informal settlements in urban neighbourhoods—that are disconnected from formal health systems. But this gap in access is not inevitable. Universal health coverage (UHC)[21]—the principle that all people should receive the health services they need, when and where they need them, without financial hardship—can be achieved. However, reaching this goal requires robust investment in primary health care (PHC), with CHWs serving as a cornerstone[22].

Malnutrition, a driver and consequence of poor health, must be addressed as an integral part of PHC. Tackling it through siloed or emergency-only approaches is neither sustainable nor effective. Instead, integrating nutrition into PHC is a highly cost-effective strategy that enables early intervention, promotes prevention, and ensures equitable access to care across the life course. The United Nations Declaration on Universal Health Coverage affirms PHC, including community-based services, as the most effective, efficient, and inclusive approach to achieving health and well-being for all. By investing in nutrition through PHC, countries can not only improve health outcomes but also reduce long-term costs and strengthen national resilience.

To do so, the Global Nutrition Report recommends that countries strengthen health systems in six key areas:

1. establishing strong governance and leadership to prioritize nutrition,
2. training and deploying health workers with nutrition expertise,
3. securing sustainable financing,
4. ensuring access to essential nutrition-related supplies,
5. embedding nutrition services into everyday health care, and
6. building reliable data systems to track progress[23].

CHWs are the frontline force that makes these pillars operational, especially in marginalized communities. Often the first—and sometimes only—point of contact with the health system, they deliver care rooted in trust and a deep understanding of cultural norms and local knowledge, including the community's needs. Their deep ties to the communities they serve make their care not only more accessible, but more effective and equitable. By extending the reach of health systems, CHWs play a critical role in delivering nutrition, preventing disease, and protecting populations during crises.

Despite their demonstrated impact and critical role, CHWs in many settings remain unpaid, undertrained, unequipped, and unsupervised. This not only undermines health outcomes for the communities they serve but also represents a missed opportunity for donors, including governments, multilateral development banks, philanthropies, and global health initiatives who are seeking high-impact investments.

Investing in CHWs Is a Smart, Scalable Solution

It delivers strong health outcomes while generating significant economic returns. For every $1 invested in their national community health worker programs, governments can yield up to a $10 return on investment[25]. This impressive return on investment is driven by three key factors:

1 **Increased productivity from a healthier population**
Enabling people to live longer, stay in school, enter the workforce, and contribute meaningfully to their communities.

2 **Cost savings from preventing health crises**
Reducing the need for expensive emergency interventions and hospital care.

3 **Job creation and economic growth**
Empowering CHWs, often women, with stable employment in their own communities.

CHWs are also essential to pandemic preparedness, prevention and response[26]. When properly supported—with training, supervision, fair pay, medical supplies, and personal protective equipment—they can lead infection prevention, support contact tracing and vaccination, deliver home-based care, and contribute to early warning systems through community event-based surveillance. For example, during the COVID-19 pandemic, professionalized CHW programs helped maintain access to care for over 5.2 million people, preventing major disruptions in essential services[27].

For over a century, CHW programs have proven their value across diverse settings—from isolated villages to densely populated urban areas.

Strengthening these programs is not charity; it is a strategic investment in more resilient health systems globally.

Investing in CHWs is not just a practical imperative—it is a moral and legal one. The World Health Organization defines the right to health as the entitlement of every individual to the highest attainable standard of physical and mental health, which requires governments to ensure that health services are available, accessible, acceptable, and of good quality for all without discrimination.

Strengthening CHW programs is a crucial way for countries to uphold this right, especially by reaching marginalized and underserved communities that formal health systems often miss.

With the right investments, CHWs can take on more specialized roles, from administering vaccines to delivering comprehensive nutrition services. This not only improves service quality and acceptance but also helps build truly people-centred, resilient, and equitable health systems.

Colette Compaoré, health worker, helps pregnant women adhere to MMS in the Ziniaré health centre in Burkina Faso.

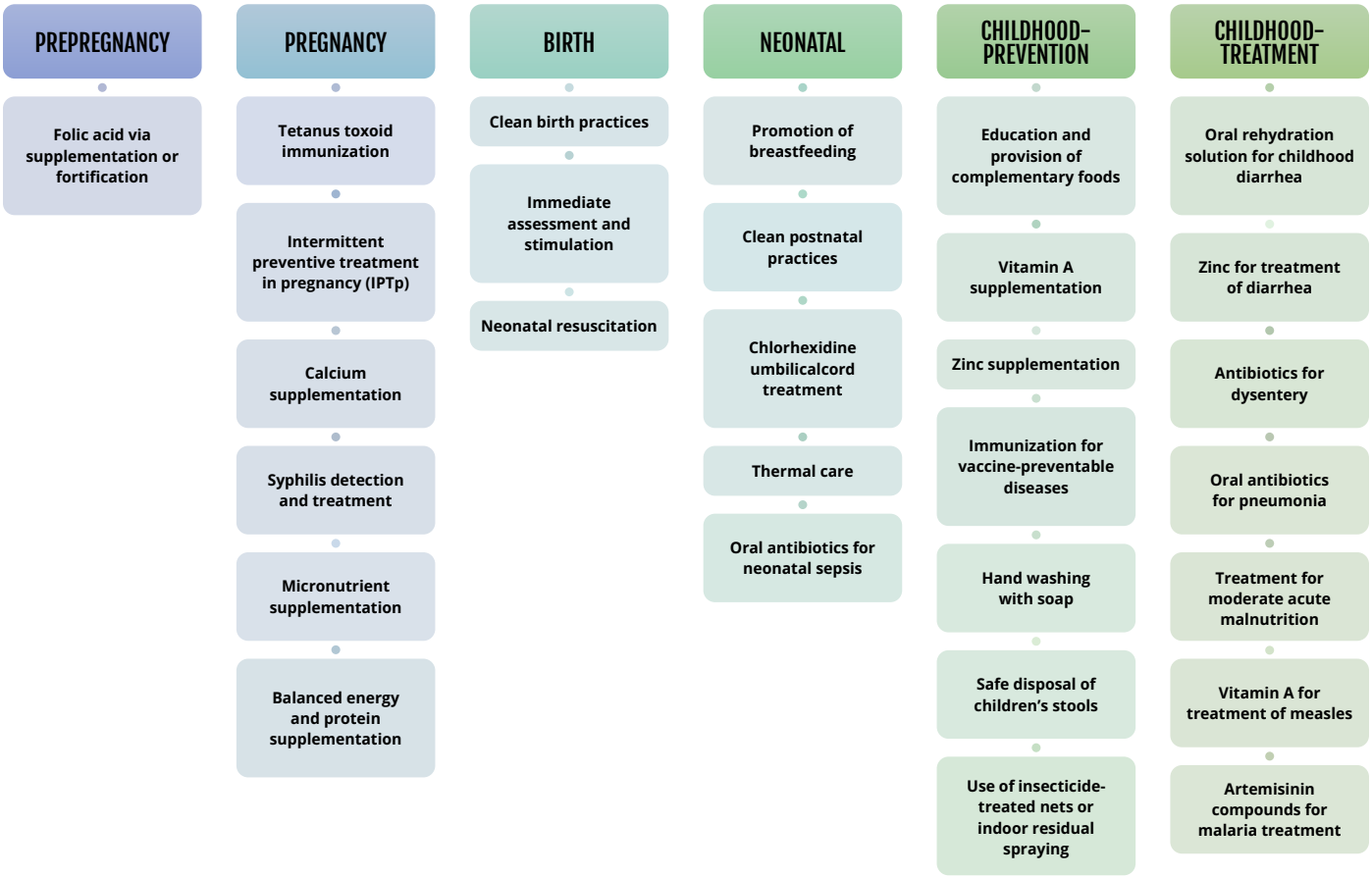
Image: © UNICEF/UNI528403/Cisse

Community Health Workers

Bridging the Gap in Access to Nutrition

CHWs are at the frontline of the fight against malnutrition. They deliver services such as nutritional screenings, breastfeeding support, referrals for acute malnutrition, and counselling on caregiving practices—all of which are critical to improving child survival and development. Deploying CHWs to consistently provide a package of 30 lifesaving health services[28] in high-burden countries could save up to 6.9 million lives annually[29], nearly halving child mortality.

30 Life-Saving Health Interventions That Can be Provided by CHWs[28]



"There is no health without health and care workers. Health information does not communicate itself. Vaccines do not administer themselves. [...] Diseases do not diagnose themselves. Medicines do not prescribe themselves. And care, compassion, and kindness do not deliver themselves."

— Tedros Adhanom Ghebreyesus
Director-General of the World Health Organization

CHWs play a vital role in efforts to increase vaccine coverage, particularly among zero-dose and under-reached populations[30]. Undernourished children are more susceptible to infections and often respond less effectively to vaccines, while vaccine-preventable diseases like measles and diarrhea can further worsen nutritional status, trapping children in a cycle of illness and undernutrition. In many low- and middle-income countries, CHWs are helping to fill critical gaps in the health workforce by delivering immunization and nutrition services.

CHWs often deliver these services side by side—by conducting growth monitoring or nutrition assessments during immunization visits, for example—enabling early detection of malnutrition, caregiver education, and timely referrals. This integrated approach improves both efficiency and outcomes, while strengthening family trust and reducing missed opportunities for care.

CHWs' trust-based, holistic approach is particularly valuable in fragile or conflict-affected settings, where undernutrition is often widespread and access to care is limited. Systematic reviews show that **CHW programs can effectively prevent, assess, and manage child undernutrition in these contexts**, notably through improved dietary practices and breastfeeding support[31].

In Mali, for example, where climate change is expected to worsen[32] already high rates of child undernutrition, integrating wasting treatment into the integrated Community Case Management (iCCM) model has shown promise. iCCM trains CHWs to treat the most common childhood illnesses—such as malaria, pneumonia, and diarrhea—in remote areas. Adding care for wasting to this model allows for earlier diagnosis, better recovery rates, and more comprehensive care[33].

> *"It's simple—without CHWs, there would be no access to primary health care in my community."*
>
> **— Sherlie Petit Homme, Haiti**

Lady Health Worker Roshan speaks to Rozan about the benefits of a package of essential nutrition services for women, on February 28, 2024 in Thatta, Sindh, Pakistan.

Image: © UNICEF/UNI535341/Bashir

Proof in Practice: How Community Health Workers Are Changing Lives

For this report, we interviewed four CHWs in Africa, the Caribbean, and South America. In every conversation, it became clear that **CHWs are far more than service providers**—they are neighbours, advocates, problem-solvers, and lifelines. Some described how they are called on at all hours, not just for health advice but for support, reassurance, and connection. Their deep ties to the families they serve, combined with intimate knowledge of local realities, allow them to respond with compassion and creativity, often under challenging circumstances and with limited resources.

Sherlie Petit Homme

The Guide // Haiti

In Delmas 32, a neighborhood in Port-au-Prince, Sherlie first saw how few people accessed care while working at a local hospital. It wasn't until she began visiting families door-to-door that she understood why: most people didn't know they had a right to free services like immunizations or malnutrition screening.

"Without community health workers, no one explains to people what they're entitled to."

But working in the community has become far more dangerous. Armed groups now control much of the capital, hospitals have closed, and medical supplies are scarce. CHWs like Sherlie navigate daily threats with no hazard pay, irregular salaries, and growing barriers to reaching families, especially those in "red zones," where entry is often impossible. Today, she believes safety has become the biggest challenge for her and her colleagues.

Despite these risks, Sherlie continues her work. For her, health care is not just a service, it's a right. And in places where systems have failed, she remains a vital connection between the people and the care they deserve.

Benard Otieno

The Generalist // Kenya

In Kenya's Nyanza region, Benard Otieno speaks with quiet pride and humility about the breadth of his daily responsibilities.

"A community health worker is generally a naturally talented being when it comes to multitasking. Every day, I begin my household visits as directed by my digital app designed to assign and remind me of the tasks for the day. These may include immunization follow-ups, nutritional assessments and rehabilitation programs, growth monitoring, mRDTs [malaria rapid diagnostic tests], and treatments for malaria, among others."

Later in his interview, Benard noted that while trainings are provided, they are infrequent and often fail to address the specific needs of CHWs. Follow-up and refresher sessions are rarely offered, and nutrition-related trainings are even less common, occurring only in response to spikes in malnutrition or outbreaks.

Benard's account reflects the need for proper training[34] and support to match the complexity of his work. In many cases, CHWs are asked to manage overlapping health needs—nutrition, infectious disease, child development—yet often receive narrow or one-time training.

Dygrace Lukwesa
The Lifesaver // Zambia

"To this day, I'm still in touch with the family and continue to support their health needs."

A few years ago, under the shade of a mango tree in Zambia's Luapula province, CHW Dygrace Lukwesa was conducting malaria tests when she encountered a mother with a two-year-old who couldn't walk. Sensing something was wrong, Dygrace conducted a mid-upper arm circumference (MUAC) assessment and diagnosed the child with severe acute malnutrition, one of the leading causes of death among children under five.

She referred the child to the nearest health facility, where they received ready-to-use therapeutic food (RUTF) and nutritional counselling. Dygrace didn't stop there. She visited the family weekly, monitoring progress and offering support. Within three months, the child was walking and thriving.

Her story shows how early detection and consistent follow-up can reverse life-threatening conditions and how CHWs build lasting bonds that extend beyond a single intervention.

Blanca Flor Rosales Borrego
The Bridge // Peru

In Trujillo, Peru, CHW Blanca Flor Rosales Borrego works with communities who often avoid health centres due to stigma, discrimination, or previous negative experiences. This dynamic is common in many parts of the world and is often linked to stigmatized conditions such as tuberculosis or HIV. However, when CHWs offer a wide range of services to all community members, they help normalize care and reduce stigma[35]. Blanca's work plays a vital role in bridging this gap and rebuilding trust in the health system.

"We are the eyes and ears of our population, and we know what's going on in every family. We are a fundamental part of the community—we restore the confidence of families and give them access to essential prevention services."

In her interview, she stressed that proximity to communities alone is not enough—trust is key. CHWs like Blanca rely on these trusted relationships to shift long-standing barriers to care, whether by encouraging handwashing, improving diets, or promoting consistent health-seeking behaviours.

Far from being limited to distributing supplements or rations, CHWs address the root causes of poor health and nutrition. They educate families on dietary diversity, hygiene, and child feeding practices, while connecting them to services and support systems that foster lasting change. This necessarily holistic, lifelong approach allows them to adapt to emerging community needs, making CHWs like Blanca a cornerstone of prevention, resilience, and equitable care.

Building Nutrition-Focused Health Systems

Key Gaps in Health Systems and Malnutrition Interventions

Across diverse settings, CHWs report facing a common set of challenges that limit their impact and compromise health outcomes. These barriers fall broadly into four categories: insufficient support and supervision, inadequate tools and supplies, lack of recognition and fair compensation, and lack of security.

Insufficient Support and Supervision

The most consistent challenge raised by CHWs is the absence of regular, meaningful compensation. Where stipends exist, they are unpredictable—sometimes delayed by months or cancelled entirely. Many CHWs are volunteers or semi-volunteers. Given that 70% of health workers are women[36], at least six million women work unpaid or underpaid in core health systems roles[37]. As a result, they are often excluded from formal training opportunities, left without supervision, and forced to balance public health duties with income-generating activities to support their families. This is a system built on goodwill, not support.

> *"I get a few days off each week to run my small business—otherwise I couldn't survive. If I could follow up with families every day, my work would be much better."*
>
> **— Dygrace Lukwesa, Zambia**

The imbalance between expectations and compensation is not lost on CHWs. Many express a desire not just for payment, but for basic dignity and recognition in the system. Associations and local groups continue to lobby for CHWs to be added to payrolls—whether through government or NGO contracts—and to receive incentives or hazard pay for work in difficult or insecure environments.

Inadequate Tools and Supplies

Shortages of equipment and infrastructure are a huge challenge for the work of CHWs and the success of health care efforts. The tools CHWs need—such as MUAC tapes, height boards, prevention materials, or digital devices—are often outdated, broken, or entirely unavailable[38]. Supplies, when provided, are rarely replenished. Many CHWs carry a small stock of medications and medical kits, but not enough to meet demand.

> *"Currently in Kenya, about 95% of CHWs have been supplied with kits to aid their work but they are never replenished in time and the kits became somehow of less importance and use to the community as we fail to give standard services."*
>
> **— Benard Otieno, Kenya**

There is also a reported lack of appropriate infrastructure. CHWs frequently deliver services without a designated space, such as a clinic or an office. While the community is often willing to organize and provide resources, such generosity is not a substitute for a sustainably funded system.

> *"The people in the community will offer their house to conduct the services. (...) Others will step in to help by donating bricks or materials to construct local spaces."*
>
> **— Dygrace Lukwesa, Zambia**

Lack of Recognition and Fair Compensation

There is a widespread lack of institutional recognition and long-term investment in CHWs. Training opportunities are irregular and often tied to specific campaigns or emergencies. This leaves CHWs without the ongoing professional development needed to respond to evolving community needs. In some regions, even access to mental health or epidemiological training (where provided) has not been matched with the tools or recognition to apply those skills effectively.

More broadly, there is a sense among CHWs that their contributions are undervalued by both public institutions and communities themselves.

> *Our work is recognized [by the government]—but only in words. There is no concrete support (...) I've seen many examples of people organizing themselves into committees to carry out activities, training, (...) seeking support from NGOs and private organizations.*
>
> **— Blanca Flor Rosales Borrego, Peru**

Even when supervisors, such as district public health officers, are committed to supporting CHWs, they themselves are limited by resource constraints. While some supervisors help CHWs plan and mobilize, others have little capacity to engage in supportive supervision[39]. This affects CHWs' motivation, accountability, level of community trust, and their ability to learn and improve. In many cases, CHWs are effectively left to manage communities on their own, without routine check-ins, performance reviews, or feedback loops.

A study in southern Mali showed that stronger supervision significantly improves cure rates in acute malnutrition treatment programs[40]. While it can increase overall costs, the difference in cost per child cured was minimal, suggesting that, with improved efficiency, investing in supervision could be a cost-effective way to strengthen CHW impact.

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Lack of Security

The cost of conflict on community health is high. In conflict-affected and fragile settings, the work of community health workers is often disrupted by political instability and insecurity. Their impact is further limited by the reduced capacity of health institutions to take on referrals[41]. Yet, with the right policies and tools, CHWs can still be effective, even in emergencies.

Mali offers one such example. In 2015, the government authorized CHWs to treat wasting outside of formal health facilities. A recent study in the conflict-affected Gao region—where extreme climatic conditions are also frequent and acute malnutrition reached 16.1%—tested a simplified approach using MUAC-only diagnosis for both severe and moderate cases of acute malnutrition and a pre-determined dose of RUTF based on MUAC screening[42]. Results showed strong recovery rates, improved coverage, and reduced RUTF supply needs.

Still, in many contexts, insecurity remains a major obstacle.

> *"In the current context, insecurity increases people's vulnerability. Some were displaced by the violence, seeking refuge in unsanitary and unsafe shelters. (...) We can only attend to people who live in areas where our safety isn't threatened. If they live in red zones, no one can reach them. Without peace, we can't work properly."*
>
> **— Sherlie Petit Homme, Haiti**

Rethinking Delivery

Making Health Systems Work for Nutrition

Despite working under extreme constraints, CHWs remain deeply committed to their communities. Many go above and beyond—mobilizing resources, holding community meetings, and maintaining services during crises or insecurity. But goodwill alone cannot sustain frontline health care. If governments and global partners are serious about achieving universal health coverage and ending child malnutrition, they must invest in the people who bring services to the doorstep.

That means ensuring CHWs are paid fairly, trained regularly, equipped properly, and recognized fully as integral members of the health system—not as volunteers, but as professionals whose work saves lives every day.

Lady Health Worker Roshan, speaks to women about good nutrition on February 28, 2024 in Thatta, Sindh, Pakistan.

Image: © UNICEF/UNI535334/Bashir

Recommendations to:

Implementing Governments

1 Ensure Fair Pay and Legal Recognition

- Integrate CHWs into national health workforce, ensuring regular and sufficient pay, with access to promotions, hazard pay, and incentives aligned with other healthcare workers.
- Formally recognize CHWs in national law and health policies as essential health workers.

Community-based health worker Adeline Ouédraogo explains MMS to Odile Konkobo, 25, in Ziniaré, Burkina Faso.

Image: © UNICEF/UNI528404/Cisse

2 Provide Training and Supervision

- Provide regular, standardized training for CHWs that goes beyond emergency or campaign-based interventions.
- Define clear roles within the primary health care systems.
- Ensure career progression and representation in decision-making.

3 Maintain Consistent and Adequate Access to Infrastructure and Supplies

- Build and maintain adequate infrastructure, including safe spaces for care delivery, transportation, rainy-season equipment, and supervision.
- Provide CHWs with consistent and replenished supplies, from medications to malnutrition monitoring tools (mid-upper arm circumference (MUAC) tapes, scales, etc.).

Recommendations to:

Donor Governments

1 Channel Long-Term and Flexible Funding for CHWs and Strengthen Primary Health Care Through Multilateral and Bilateral Investments

- Provide robust, long-term and flexible funding to global health initiatives—such as the Child Nutrition Fund, Gavi, the Global Financing Facility, and the Global Fund—with earmarked support for integrated, CHW-delivered services across child and maternal health, including nutrition, immunization, and disease prevention.
- Leverage donor leadership roles within these global health initiatives governance bodies and replenishment platforms to ensure CHWs are prioritized in strategy, financing, and program implementation.
- Foster synergies among donors and partners, local ownership and sustainability through coordinated financing mechanisms at the country level to reduce fragmentation, increase the impact of primary health care investments, and ensure donor support is aligned with national systems and national health and social protection strategies.
- Complement multilateral contributions with bilateral investments with implementing countries and non-governmental organizations (NGOs) that strengthen community health programs, enabling CHWs to deliver across sectors and reach underserved populations.

2 Promote Integrated, Community-Based Health Systems

- Invest in integrated service delivery models that combine nutrition, immunization, maternal and newborn care, infectious disease, and social protection—through community-rooted, primary health systems.
- Expand CHW capacity through training, digital tools, and reliable supervision.
- Support national monitoring and evaluation systems to capture CHW contributions and drive performance across sectors and improve nutrition outcomes.

3 Promote CHW Leadership and Inclusion in Global Health

- Fund CHW-led organizations and advocacy efforts to strengthen domestic recognition, financing priorities, and policy change.
- Ensure CHWs and other frontline actors are meaningfully represented in global health decision-making platforms (e.g. Gavi Board, GFF Investors Group, etc.) and actively participate in donor-funded research and program management.

While governments must lead in professionalizing and scaling CHW programs, global health initiatives, and financing, institutions are essential partners in shaping how nutrition is prioritized, funded, and delivered through health systems. The following section highlights opportunities to further embed nutrition within resilient, people-centred health care models supported by global health initiatives and global financing institutions.

Driving Change

Through Global Health Initiatives and Global Financing Institutions

Strengthening Systems The Role of Global Financing

Global health initiatives—such as the Global Financing Facility for Women, Children and Adolescents (GFF) and Gavi, the Vaccine Alliance (Gavi)—as well as multilateral actors like the World Bank, have been pivotal in advancing progress toward health systems strengthening and in achieving global nutrition goals. Emerging financing mechanisms, such as the Child Nutrition Fund (CNF), also strive to mobilize global and domestic resources to improve coordination and the delivery systems to prevent and treat malnutrition. These institutions understand that nutrition is deeply interconnected with other sectors—including agriculture, education, and social protection—and that progress requires coordinated, cross-sectoral approaches.

Global health initiatives also recognize that strong primary health care systems and well-supported CHWs are essential to delivering nutrition services effectively. By supporting the integration of nutrition into broader health programs, fostering local ownership, promoting sustainable financing, leveraging technology, and ensuring that spending is tracked and aligned with the implementing countries' national priorities, these actors have laid the foundation for more resilient and equitable systems.

Donors—like high-income countries, granting bodies, and the private sector—have a critical role to play in this ecosystem. By investing in global health initiatives and the International Development Association, they can help shape priorities and push for alignment around the most impactful and cost-effective solutions—like scaling access to essential nutrition interventions through empowered CHW programs. Donor influence is also key to promoting greater coordination among global health initiatives, reducing fragmentation, and maximizing the reach and efficiency of every dollar spent.

Workitu Abera is a health worker at Kolabe Bale Health Post in Sire, Oromia Region, Ethiopia. She's conducting a routine check-up with Birke Mulugeta who is 9-months pregnant.

Image: © UNICEF/UN0792406/Ayene

Spotlight
The World Bank

The World Bank plays a dual role in the global fight against malnutrition as a thought leader and one of the largest funders of nutrition-sensitive programs. Its growing influence on nutrition policy and financing is significant to achieving Sustainable Development Goal 2 (Zero Hunger) and accelerating progress toward universal health coverage.

The World Bank as a Major Nutrition Funder

With project approvals for nutrition-sensitive investments averaging US$5 billion annually, the World Bank is a global trendsetter in development financing. Nutrition has become more visible in the Bank's corporate agenda, including its commitment to expand health services to 1.5 billion people by 2030. However, a specific target for nutrition within this broader goal would be key in ensuring progress and accountability. At the moment, it remains unclear how many of these 1.5 billion people will be reached by nutrition programs and if progress in key nutrition interventions will be reported.

The Bank's adoption of a new 500 million–person target for social protection coverage and its focus on early years and reproductive health in the International Development Association's 21st replenishment both offer new pathways for nutrition integration[44]. However, to maximize impact, the World Bank must ensure these investments align with the most cost-effective interventions, many of which lie in the health sector, and prioritize delivery systems that reach families where they are. This includes earmarking and scaling funding for CHWs who deliver nutrition-specific and nutrition-sensitive interventions, ensuring that frontline delivery systems are robust enough to translate financing into impact at the community level.

Volunteers from the community cook traditional Lao recipes with more nutritious ingredients to ensure that the children eat healthier meals.

Image: © Bart Verweij / World Bank / CC BY-NC-ND 2.0

The World Bank as a Thought Leader

As one of the most influential institutions shaping global health and nutrition policy, the World Bank's latest Nutrition Investment Framework reaffirms just how critical smart, targeted action is if we are to meaningfully reduce malnutrition and how health systems should be leveraged to achieve this goal[43].

The Framework offers a clear message: building stronger health systems can improve nutrition outcomes, but only if nutrition is at the core of the design. Three takeaways are especially important for nutrition stakeholders:

Betty Nabiteeko, 38, teaches mothers with small children about nutrition at her home near Mityebili, Uganda.

Image: © Stephan Gladieu / World Bank / CC BY-NC-ND 2.0

1 Nutrition must be delivered across systems—health alone can't do it.

Fighting malnutrition requires much more than health clinics and supplements. Social protection systems help families afford nutritious food. Agriculture policies determine what's grown. Schools deliver meals and shape lifelong eating habits. Water and sanitation affect how nutrients are absorbed. And the private sector can innovate and scale up solutions, such as the manufacturing and distribution of fortified foods. The health sector is essential—but not sufficient on its own. As revealed in the interviews, CHWs already operate at the intersection of sectors, from health and education to social protection. Their multisectoral reach makes them essential to ensuring that nutrition interventions actually reach the families who need them.

2 But health systems remain the frontline for the most cost-effective solutions.

Not all interventions offer equal impact. The World Bank's analysis in the Framework highlights a core set of proven interventions that deliver high returns in reducing stunting, wasting, and anemia—from vitamin A and zinc supplementation to breastfeeding counselling, cash transfer and behaviour change communication, as well as antenatal nutrition through Multiple Micronutrient Supplementation (MMS) and Intermittent Preventive Treatment for malaria in pregnancy (IPTp). Crucially, almost all of these depend on a well-functioning health system. Without trained frontline workers, reliable supply chains, and integration into primary care, even the best interventions fall short.

3 More funding for health is not enough—nutrition must be deliberately built in.

Many countries have increased health spending without a corresponding rise in nutrition funding. Why? Because unless nutrition is explicitly prioritized through universal health coverage benefit packages, dedicated budget lines, and performance incentives for delivering these interventions through primary health care, it risks being left behind. The Framework emphasizes that nutrition must be fully integrated into the structure of health financing, tracked through data systems, and delivered by equipped, professional health workers, especially CHWs. Here, the World Bank should lead the way in ensuring CHWs are salaried, supplied, skilled, and supervised, and make funding available for countries to implement this standard.

Case Study

Madagascar: One System, Greater Impact

In Madagascar, where child malnutrition drains an estimated 7-12% of the GDP, the government made a bold move in 2017. With World Bank support, it merged two parallel delivery systems—health and nutrition—into a single, integrated community platform. In a country with limited financial resources and a high burden of malnutrition, the inefficiencies of duplication were simply unaffordable.

Backed by US$ 90 million in IDA financing (plus US$ 10 million from Power of Nutrition), the project emphasized team integration, joint training, and aligned supervision. While the shift posed challenges, especially for field teams unaccustomed to coordination, it paid off. With over 9,000 CHWs and 500 frontline health workers trained and 4,000 community sites strengthened with nutrition products and equipment, the expected return on investment is striking: a benefit-cost ratio of 18.9, with each child death averted costing only US$ 2,700.

Crucially, the project linked health and nutrition outcomes in its metrics, tracking antenatal care visits, immunization, and nutrition service coverage together. Operational research later showed that in food-insecure areas, preventive nutrition for young children reduced stunting by 9%, prompting national scale-up. To meet demand, Madagascar partnered with a local manufacturer to boost supplement production, demonstrating how strengthened health systems can catalyze cross-sectoral action.

This model shows the power of integration. By building community platforms that serve multiple needs—and drawing in actors beyond health—countries can make rapid, cost-effective progress on complex challenges like child malnutrition.

The Basic Health Centre of Itampolo, Madagascar. In the photo, children are now having their height measured—a key step in assessing growth and identifying potential cases of stunting or malnutrition.

Image: © UNICEF/UNI839810/Andrianantenaina

Recommendations to:

The World Bank

1 Scale Up Nutrition Investments in Primary Health Care

- Increase approval of nutrition-sensitive projects that prioritize community-led interventions and integration within primary health care systems.
- Expand the proportion of food and nutrition security projects that address the health-related dimensions of malnutrition, with a focus on prevention, early detection, and treatment at the community level.
- Ensure that nutrition services delivered by CHWs are embedded within broader efforts to expand universal health coverage (UHC), especially in underserved and fragile settings.

2 Set Measurable Goals and Drive Accountability

- Define clear, time-bound targets for the population reached by nutrition and CHW-delivered services, aligned with the Bank's overarching goal of reaching 1.5 billion people with health services.
- Publish disaggregated metrics by intervention type (e.g., stunting, wasting, anemia) to improve transparency and inform decision-making.

A group of women attend a community session about good nutrition on February 28, 2024, in Thatta, Sindh, Pakistan.

Image: © UNICEF/UNI535330/Bashir

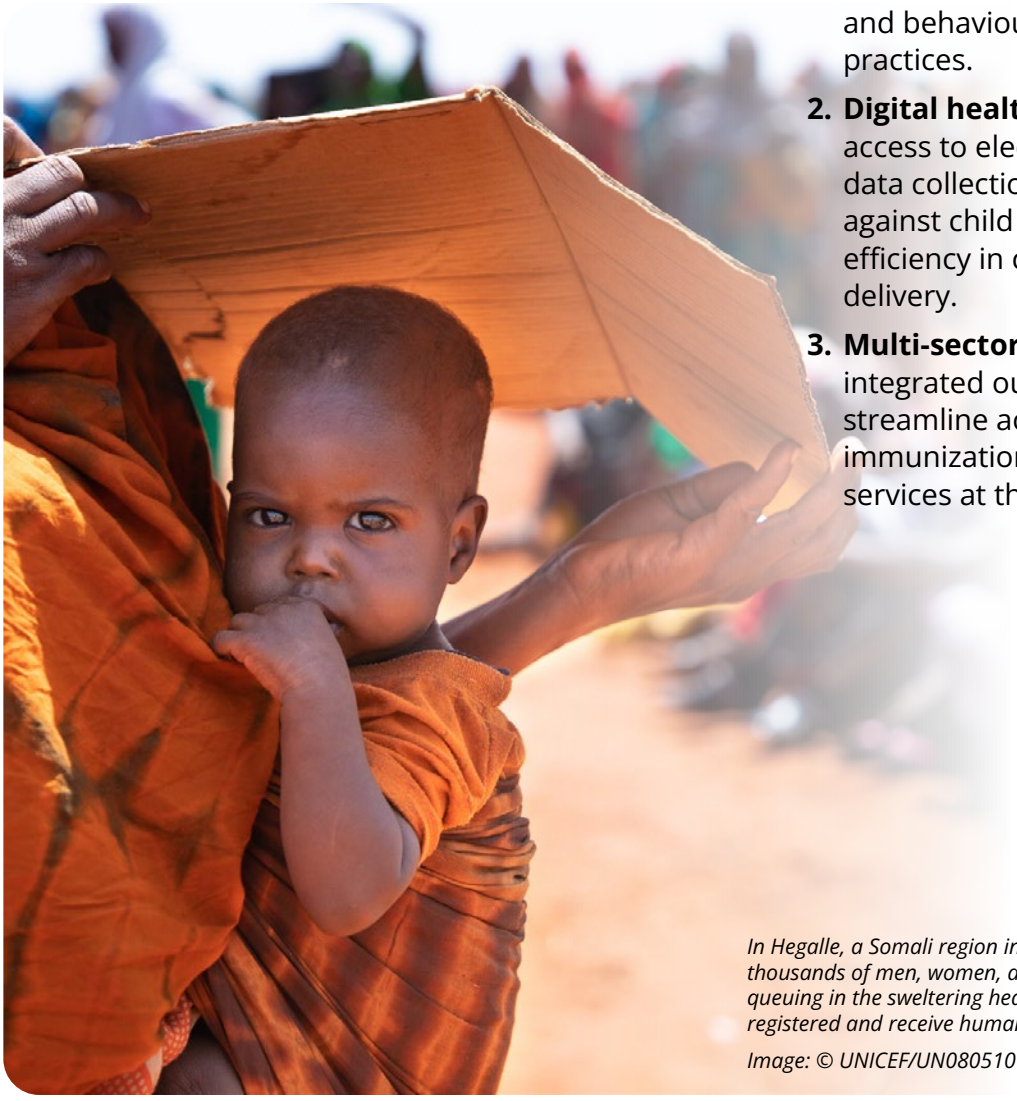
Spotlight The Child Nutrition Fund

The CNF, led by UNICEF, is a financing mechanism designed to support country-led efforts to scale up child and maternal nutrition services, policies, and commodities, particularly in low- and middle-income settings. CNF investments aim to build resilience by coordinating global investments based on needs, strengthening the local governments' capacity to invest domestic resources by matching them, and supporting the production and delivery of essential nutrition supplies.

A Systems-Based, Community-Led Model

The CNF prioritizes interventions that strengthen government-led health systems and make the most of existing local platforms. Drawing on a project implemented with the Ethiopian government, several key features of the CNF's approach to strengthening primary health care emerge: centring local structures, community workers, and technology.

1. **Community-led service delivery:** Training health workers and local leaders to drive uptake of health and nutrition services and strengthen social and behaviour change to improve practices.
2. **Digital health integration:** Expanding access to electronic tools to improve data collection and monitor progress against child nutrition indicators and efficiency in community health service delivery.
3. **Multi-sectoral delivery:** Promoting integrated outreach events that streamline access to nutrition, immunization, and maternal health services at the same point of access.



In Hegalle, a Somali region in Ethiopia, thousands of men, women, and children are queuing in the sweltering heat waiting to be registered and receive humanitarian aid.

Image: © UNICEF/UN0805101/Pouget

Case Study

Ethiopia's Community Health System Transformation

In Ethiopia, the CNF is supporting government-led efforts to strengthen community health structures and bring critical services to mothers and children in hard-to-reach areas.

A cornerstone of the CNF's support in Ethiopia has been the training of over 3,100 community health workers. In 2024 alone, they conducted more than 36,000 house-to-house visits and led 1,700 community conversation sessions—reaching almost 255,000 people with key nutrition and health information. These conversations foster community trust, shift behaviours, and create demand for essential services.

To improve the quality and efficiency of service delivery, UNICEF facilitated the distribution of 966 tablets across 635 health posts and 136 health centres, helping digitize the community health information system. These tools are critical for tracking child nutrition indicators and improving accountability at the local level.

An innovative delivery model, the Quarterly Kebele Health and Nutrition Days (KHNDs), has brought a multi-sectoral lens to the delivery of services. By creating a one-stop shop for mothers and caregivers in each kebele (or neighbourhood) once every quarter, the approach reduces access barriers and improves efficiency. During recent KHNDs:

102,000 children (6–59 months) received vitamin A supplementation.

100,000 children (24–59 months) were dewormed.

10,300 zero-dose children were immunized.

216,000 children were screened for acute malnutrition.

13,500 pregnant women received iron-folic acid supplements

The CNF is also supporting the scale-up of the Enhanced Community-Based Nutrition (eCBN) model, in which Village Health Leaders support community frontline workers and kebele leaders by raising awareness in the communities and providing services ranging from cooking demonstration to micronutrient supplementation, vaccination, and more. The eCBN model began in four districts and now reaches 214,000 children under five across 12 districts. With support from Gavi, the Vaccine Alliance this integrated approach is expanding into the Afar, Amhara, and Sidama regions, prioritizing areas affected by climate stress and food insecurity[46].

The CNF's work in Ethiopia demonstrates how targeted investments in community health systems, digital tools, and coordinated service delivery can yield transformative outcomes for child nutrition.

This approach reflects a growing recognition that nutrition gains are best achieved when services are brought closer to families—through health systems that are responsive, accountable, and integrated.

Spotlight The Global Financing Facility for Women, Children and Adolescents

The GFF takes a strategic, systems-focused approach to improving nutrition outcomes by strengthening primary health care and addressing the underlying drivers of malnutrition across sectors, such as education and social protection. Recognizing that nutrition gains are inseparable from robust public health systems and efficient financing, the GFF supports countries to integrate high-impact, nutrition-specific interventions into broader health reforms, including primary health care.

At the heart of the GFF's approach are four interlocking strategies:

1. **Mobilizing and aligning resources for nutrition** within national health plans.
2. **Strengthening community health systems**, with a focus on equipping and training frontline workers, including CHWs, on child feeding practices.
3. **Improving supply chains** to ensure access to essential nutrition commodities.
4. **Enhancing data systems** to generate actionable insights and inform investment decisions.

The GFF also promotes multisectoral coordination—bridging gaps between health, education, agriculture, and social protection—to ensure that nutrition is addressed holistically. This approach has led to significant gains: nearly one-third of the GFF's portfolio directly supports nutrition outcomes, and **for every $1 invested in reducing undernutrition, countries stand to gain $23 in long-term returns.**

Building Country Capacity for Sustainable Financing

Underlying the GFF's impact is its commitment to building lasting public financial management capacity within governments, namely by leveraging its unique position within the World Bank to support health financing in low-income settings. Tools like **Resource Mapping and Expenditure Tracking (RMET)** are helping countries improve planning, prioritize investments, and ensure that national health plans, including community health systems, are realistically financed and implemented.

Cường was born prematurely in 2021 at Điện Biên General Hospital, weighing just 2,3 kg. With guidance from healthcare workers trained under UNICEF's essential newborn care programme, his parents, Sùng Thị Sia and Mùa A Nhàm, practiced kangaroo care, exclusive breastfeeding, routine immunization, and other essential care techniques.

Image: © UNICEF/UNI711903/Luu Thu Huong

Case Study

Performance-Based Nutrition Improvements in Mali

Mali faces acute challenges in child nutrition, with more than one in four children suffering from chronic malnutrition and widespread food insecurity affecting nearly a quarter of the population.

Since 2019, the GFF has partnered with the government of Mali to strengthen nutrition services through a performance-based financing model, with a strong focus on reaching underserved regions in the north. With support from the GFF, the government is expanding its community health worker program, strengthening supply chains for medical supplies and equipment, enhancing access to health services for adolescents, and addressing gender-based violence[47].

This results-based approach has had a clear impact: between 2019 and 2023, the proportion of children aged 6-59 months screened for acute malnutrition by CHWs increased from 55% to 90%. In parallel, CHWs received enhanced training in child feeding practices and counselling, improving both the quantity and quality of services delivered.

The GFF's approach in Mali also emphasizes domestic resource mobilization at the local level. In partnership with the Centre Sahélien de Prestations d'Études d'Écodéveloppement et Démocratie Appliquée, local governments are developing nutrition action plans and building advocacy capacity.

These efforts are already paying off: the municipality of Sirakorola created a new budget line for community nutrition programs, while Muéguetan secured funding to enroll three community-based health organizations into the national social security scheme, increasing financial protection for frontline providers.

Together, these country experiences highlight how **the GFF model—focused on sustainable financing, integrated service delivery, and community-driven health systems**—offers a powerful blueprint for improving nutrition at scale.

A group interview in Anefif. Information shared on what women eat after having given birth to the difference between themselves and their children. Anefif, Northern Mali, January 2007.

Image: © Emilia Tjernström

Spotlight Gavi, the Vaccine Alliance

Gavi is a private-public partnership that brings together multilateral partners, foundations, the private sector, donor governments, civil society organizations, and implementing countries to ensure all children have access to essential vaccines. With the support of donors, Gavi takes on part of the cost of vaccines to create a production incentive and secure the supply. This co-financing policy helps low-income countries afford essential vaccines.

Infectious diseases and malnutrition are among the main causes of child mortality. Worse, they often intertwine and reinforce each other's consequences. But when we address both at once, we can break this cycle. Tackling childhood undernutrition and low immunization coverage requires coordinated action that goes beyond siloed health services.

Immunization day at Katooke Health Centre 3 in Mukono District, Uganda in November 2024.

Image: © Jjumba Martin/GAVI

Case Study

Driving Integrated Solutions for Child Health and Nutrition in Pakistan

Recognizing the deep links between nutrition, immunization, and maternal care in the first 1,000 days of a child's life, Gavi, The Power of Nutrition, and the Aga Khan Foundation launched the Systems Strengthening, Nutrition and Immunisation in Pakistan (SNIP) program in 2024. This three-year, US$ 7.2 million initiative targets seven high-need districts across 53 Union Councils, reaching nearly 1.4 million people.

Pakistan faces some of the world's highest rates of low birth weight and child undernutrition—drivers of stunting, wasting, and low vaccine coverage. In rural areas, up to 32% of newborns are affected. Many of the contributing factors—poor access to antenatal care, low institutional delivery rates, and missed opportunities for early childhood interventions—also result in zero-dose children (those who have never received a single vaccine)[48].

To address these barriers, SNIP integrates maternal nutrition, and immunization services, while strengthening their delivery through primary healthcare, aiming to:

Implemented by the Aga Khan Development Network, the program combines community-based outreach with system-level coordination, acknowledging that integration must be people-centred and evidence-driven. Social and behaviour change campaigns address cultural and gender barriers, while monitoring systems enable real-time feedback, continuous improvement, and policy learning.

SNIP not only delivers vital care but also generates operational evidence on how integrated models can improve equity, efficiency, and impact—reinforcing Gavi's commitment to a holistic health system transformation globally.

1. Reach 48,000 zero-dose children and increase full immunization coverage by 35% in three years.
2. Reduce stunting by 2% and wasting by 1.5% annually in target areas.
3. Empower women through improved access to health services and knowledge.
4. Strengthen local systems for joint delivery of nutrition and immunization services at the community level.

Recommendations to:

Global Health Initiatives

1 Align and Finance Country-Led Community Health Strategies

- Support country-led, integrated, and inclusive community health strategies by coordinating financing, reducing out-of-pocket costs with a view of eliminating them for the poorest, and aligning budgets.

2 Professionalize and Institutionalize CHWs

- Promote fair pay, standardized training, regular supervision, risk protection, and career progression for CHWs—guided by World Health Organization (WHO) standards[49].

3 Strengthen Resilience and Outreach Capacity

- Support CHWs to navigate climatic challenges, remote settings, and crisis-affected communities safely by collaborating with implementing countries to improve outreach through infrastructure or mobility partnerships.

4 Drive Political Commitment and Accountability

- Build political will through high-level advocacy, engagement with influencers, and evidence-based investment cases.
- Establish global accountability frameworks with common indicators, gender-disaggregated data, and measurable milestones to track progress and improve impact.

Call to Action

Turning Evidence Into Impact

The evidence is clear: professionalizing community health workers is one of the most effective, scalable ways to deliver integrated primary health care and nutrition services to those most in need.

Throughout this report, we've shown that this yields outsized returns—not only by improving health and nutrition outcomes, but also by strengthening health systems, unlocking economic gains, and advancing gender equity.

Yet despite their central role, CHWs remain undervalued and underfunded. **This is a failure not of ideas, but of prioritization.**

Donor governments and multilateral institutions now have an opportunity—and a responsibility—to act. By supporting national governments with long-term, predictable financing and policy alignment, they can help shift CHW programs from fragmented and short-term initiatives into institutionalized pillars of resilient health systems. Strategic, coordinated investments can support countries to implement sustainable CHW models that are equitably paid, adequately trained, and fully embedded in primary health care.

For governments in high-burden settings and advocates on the ground, this report also offers a tool to build momentum: to advocate for increased domestic investment, to align with existing health and nutrition priorities, and to engage development partners with a shared, evidence-based agenda.

The pathway to better nutrition outcomes runs through strong community-based health systems—and CHWs are the foundation. With political will, targeted financing, and collaborative action, we can transform community health work from an underfunded stopgap into a cornerstone of equitable, integrated care.

The moment for bold investment is now.

To build resilient, equitable health systems, we urge donor countries, implementing governments, global health initiatives, and the World Bank to invest in and empower CHWs. Support must go beyond rhetoric; it must encompass fair pay, legal recognition, training, supplies, and inclusion in decision-making. Transparent funding, inclusive governance, and global accountability are critical to ensuring no community is left behind.

By standing with CHWs, health systems can become more responsive to the nutritional needs of populations—leading to better health, reduced inequality, and stronger, more inclusive development.

Annex: Interview Questionnaire

1. Can you introduce yourself and specify where and in which community, you work in?
2. Describe a day in your life as a community health worker - what are your areas of expertise?
3. How does your government support your work in the community? Do you receive financial compensation, training, supervision, and access to necessary supplies?
4. What role does Primary Health Care (PHC) play in addressing malnutrition (and infectious diseases) in your community?
5. Can you share examples of how Community Health Workers (CHW) have improved access to nutrition interventions and their delivery in your area?
6. Can you provide a personal example where your work had a direct impact on improving nutrition outcomes in your community?
7. What are some of the most significant challenges you face when working as a Community Health Worker, and more specifically, when delivering nutrition and health interventions within your community?
8. What gaps do you see in the current health system that hinder the delivery of nutrition interventions? What additional support do you need to be more effective in your role?
9. Have there been any examples of local actors or organizations working together to address these gaps? If so, can you describe how the community worked to address these challenges?
10. Based on your experience, what recommendations would you give to your government to better support community health workers? And/or to the multilateral organizations and donor countries to better support your government in strengthening primary health care and the community health workers delivering it?

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